## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED		
		445540			R		
445516		B. WING			08/10/2018		
NAME OF PROVIDER OR SUPPLIER  CREEKSIDE HEALTH AND REHABILITATION CENTER				30	TREET ADDRESS, CITY, STATE, ZIP CODE  06 W DUE WEST AVE  1ADISON, TN 37115		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROFILE OF T		BE	(X5) COMPLETION DATE
{K 000}	by the State of Tenr Division of Health L Office of Health Ca all previously cited of During this Life Safe Health and Rehab of compliance with the Tennessee Departh Licensing Health Ca 1200-08-6 Standard National Fire Protect Life Safety (2012 East	Survey revisit was conducted nessee Department of Health icensure and Regulations re Facilities on 07/02/2018 for deficiencies on 05/14/2018. ety Survey revisit, Creekside was found in substantial e requirements of the Rules of ment of Health Board for are Facilities Chapter ds for Nursing Homes and etion Association (NFPA) 101	{K 0	00}	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445516			R			
Line and the second		B. WING			08/	10/2018		
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
CBEEKS	INE HEALTH AND DE	HABILITATION CENTER		:	306 W DUE WEST AVE			
CKEEKS	DIDE REALITIAND RE	ENABILITATION CENTER		ı	MADISON, TN 37115			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE	
					DEFICIENCY)			
{E 000}	Initial Comments		{E 0	00}				
1	During the emerge	ency preparedness portion of						
		ey on 05/14/2018, no						
1		ited under emergency						
	preparedness.	<b>5</b> ,						
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPORTUGE IDENTIFICATION NUMBER A BUILDING 01 - MAIN BUILDING

FORM APPROVE OMB NO 0938-038

(X3) DATE SURVEY COMPLETED

445516

B. WING.

05/14/2018

STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 306 W DUE WEST AVE CREEKSIDE HEALTH AND REHABILITATION CENTER MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 10 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRECIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K321 K 000 K 000 INITIAL COMMENTS 5/28/18 Door closers were installed on room 216 and 219 on A Life Safety Code Survey was conducted by the 5/31/18. State of Tennessee Department of Health Division of Health Licensure and Regulations 2. A 100% audit of the building Office of Health Care Facilities on 05/14/2018. was performed on 5/14/18 During this Life Safety Survey, Creekside Health by the Maintenance Director and Rehab was found not in substantial to ensure all other areas compliance with the requirements of the Rules of requiring automatic closing Tennessee Department of Health Board for devises were present as Licensing Health Care Facilities Chapter required. 1200-08-6 Standards for Nursing Homes and National Fire Protection Association (NFPA) 101 3. A monthly check of all doors Life Safety (2012 Edition). requiring self or automatic \* All penetrations requiring Fire Stop shall be closing devises will be completed weekly by the repaired in accordance with a tested and approved Fire Stop System meeting the Maintenance Director for a requirements of the UL (Underwriters Laboratory) period of (1) month then assembly to which the Fire Stop is being applied. monthly for (2) additional The system used shall be recorded and months June - August 2018 documentation shall be maintained for the life of to ensure compliance the installation. with F321. The Maintenance Director \* All damaged, painted, or corroded sprinklers Was in-serviced on the shall be replaced in accordance with NFPA 25, Requirements noted on Standards for the Inspection, Testing, and the 2567 on 5/28/18. Maintenance of Water-Based Fire Protection Systems (2011 Edition). 4. The results of the weekly & K 321 Hazardous Areas - Enclosure K 321 monthly audits will be presented CFR(s): NFPA 101 SS=D in the monthly Quality Assurance meeting to assure compliance Hazardous Areas - Enclosure with the requirements of F321. Hazardous areas are protected by a fire barrier June - August 2018. having 1-hour fire resistance rating (with 3/4 hour The Quality Assurance Performance fire rated doors) or an automatic fire extinguishing Improvement Committee will include system in accordance with 8.7.1 or 19.3.5.9. but not be limited to the following: When the approved automatic fire extinguishing

ABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

system option is used, the areas shall be

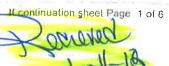
TITLE

NHA

(X6) DATE

Any deficiency statement ending with an as explication to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether ound a plan-of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued regram participation.

Facility ID: TN1939



		TH AND HUMAN SERVICES RE & MEDICAID SERVICES				M APPROVE 0 . 0938-03	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUI		(X1) PROVIDER/SUPPLIFIE/CLIA IDENTIFICATION NUMBER	1 ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED	
		445516	B WING		05	/14/2018	
	PROVIDER OR SUPPLIE	EHABILITATION CENTER	30	REET ADDRESS, CITY, STATE, ZIP CODE 6 W DUE WEST AVE ADISON, TN 37115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE	DULD BE	COMPLETION DATE	
K 321	partitions and door Doors shall be self and permitted to ha protective plates the from the bottom of Describe the floor	ner spaces by smoke resisting is in accordance with 8.4closing or automatic-closing ave nonrated or field-applied at do not exceed 48 inches	K 321	Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Ser Director, Dietary Manager, Houseke & Laundry Director, and Maintenand Director.	vices eping		
Control to the second s	c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection I (exceeding 64 gallo f. Combustible Stora (over 50 square feet g. Laboratories (if cl Hazard - see K322) This REQUIREMEN by:	rired Heater Rooms than 100 square feet) nce, and Paint Shops ms (exceeding 64 gallons) Rooms ns) age Rooms/Spaces assified as Severe  T is not met as evidenced ons, the facility failed to areas.				*	
re w a	10:53 AM, revealed	4/20188 between 10:50 AM the following medical doors were not equipped (2012 Edition)					

The maintenance assistant was present when these deficiencies were identified, and were later

LOUISTER CONTINUE **FORM APPROVEL** OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 05/14/2018 445516 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 306 W DUE WEST AVE CREEKSIDE HEALTH AND REHABILITATION CENTER MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BF PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K353 K 321 K 321 Continued From page 2 1. The sprinkler head noted in room acknowledged by the administrator during the exit 19 has been cleaned to remove conference on 05/14/2018. 5/28/18 dust and paint. K 353 Sprinkler System - Maintenance and Testing K 353 | CFR(s): NFPA 101 SS=D 2. A 100% inspection of all sprinkler heads was performed by the Sprinkler System - Maintenance and Testing Maintenance Director to ensure Automatic sprinkler and standpipe systems are all sprinkler heads meet the inspected, tested, and maintained in accordance requirements of K353 from with NFPA 25, Standard for the Inspection, 5/14/18 through 5/18/18. Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, 3. A monthly check of all sprinkler maintenance, inspection and testing are heads will be performed maintained in a secure location and readily weekly by the Maintenance available. a) Date sprinkler system last checked Director for (1) month then monthly for (2) additional b) Who provided system test months June - August 2018 to ensure compliance c) Water system supply source with K353. The Maintenance Director Provide in REMARKS information on coverage for was in-serviced on the any non-required or partial automatic sprinkler requirements noted on system. the 2567 on 5/28/18. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 4. The results of the weekly & This REQUIREMENT is not met as evidenced monthly audits will be presented in the monthly Quality Assurance

The finding included:

maintain the sprinkler system.

Observation on 05/14/2018 at 10:08 AM, revealed a painted sprinkler in first closet of room 19. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.5 (2012 Edition), NFPA 25, 5.2.1.1.1 (2011 Edition) NFPA 25, 5.2.1.1.2 (2011 Edition)

Based on observations, the facility failed to

The maintenance assistant was present when the

Director.

meeting to assure compliance

June - August 2018.

with the requirements of K353.

The Quality Assurance Performance Improvement Committee will include

but not be limited to the following:

Director of Nursing, Unit Managers,

Business Office Manager, Social Services

Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance

Administrator, Medical Director,

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVEL UMB NO. 0938-039 (X3) DATE SURVLY

ESTATEME	NT OF DEFICIENCIES FOR CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING	(X3) DA	TE SURVEY MPLETED
-		445516	B WING		05	/14/2018
		HABILITATION CENTER	3 N	TREET ADDRESS, CITY, STATE, ZIP CODE  06 W DUE WEST AVE  MADISON, TN 37115  PROVIDER'S PLAN OF CORRECTION	N	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353 K 919 SS=D	conference on 05/14 Electrical Equipment CFR(s): NFPA 101 Electrical Equipment List in the REMARKS Chapter 10, Electrical	ified, and was later e administrator during the exit l/2018 Other - Other S section any NFPA 99 Il Equipment, requirements	<b>K</b> 353	<ol> <li>The electrical cord located in the media room was replaced on 5/14/18.</li> <li>A 100% audit of the building was performed from 5/14/18 through 5/18/18 to ensure no additional power cords were improperly modified.</li> </ol>		5/28/18
	but are deficient. This applicable Life Safety citation, should be independent of the chapter 10 (NFPA 98). This REQUIREMENT by:  Based on observation maintain electrical equality. The finding included:  1. Observation on 05/2 revealed a modified electrical taped) on the room.  NFPA 101, 19.5.1.1 (2)	is not met as evidenced  ns, the facility failed to  uipment.		<ol> <li>A monthly check of the building will be performed weekly by the Maintenance Director for (1) month then monthly for (2) additional months June – August 2018 to ensure compliance with K919.         The Maintenance Director was in-serviced on the requirements noted on the 2567 on 5/28/18.     </li> <li>The results of the weekly &amp; monthly audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of K919.</li> </ol>		
K 920 E	deficiency was identific acknowledged by the a conference on 05/14/2	administrator during the exit 018. Power Cords and Extens	K 920	June – August 2018.  The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	<b>P</b> O	

## · MINTELL, USTITIZU DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVE** OMB NO. 0938-039 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A. BUILDING 01 - MAIN BUILDING B. WING \_ 445516 05/14/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 306 W DUE WEST AVE CREEKSIDE HEALTH AND REHABILITATION CENTER MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K920 K 920 K 920 Continued From page 4 Power strips in a patient care vicinity are only 1. The personal equipment plugged used for components of movable Into medical grade power strips in 5/28/18 patient-care-related electrical equipment Room 37 & 112 were unplugged From the medical grade power (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of strips and plugged into UL 1363 10.2.3.6. Power strips in the patient care vicinity grade power strips on 5/14/18. may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident The extension cords located in rooms that do not use PCREE. Power strips for Room 20 and Room 5 were PCREE meet UL 1363A or UL 60601-1. Power removed on 5/14/18. strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient The unapproved power strips care rooms, power strips meet other UL located in Room 3 and Room 217 standards. All power strips are used with general were removed on 5/14/18. precautions. Extension cords are not used as a substitute for fixed wiring of a structure. 2. A 100% audit of the building Extension cords used temporarily are removed was performed from 5/14/18 immediately upon completion of the purpose for through 5/18/18 to ensure which it was installed and meets the conditions of no additional personal equipment 10.2.4. was plugged into a medical grade 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 power strip, no extension cords (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 were present, and no unapproved This REQUIREMENT is not met as evidenced power strips were located in the building. Based on observations, the facility failed to maintain electrical equipment. A monthly check of the building will be performed

The findings included:

- 1. Observations on 05/14/2018 between 9:38 AM 10:35 AM, revealed personal equipment plugged into medical grade power strips in the following locations:
- a. Room 37
- b. Room 112

NFPA 99, 10.2.3.6 (2012 Edition)

2. Observations on 05/14/2018 between 10:10 AM - 10:20 AM, revealed extension cords in the

Facility ID: TN1939

weekly by the Maintenance Director for (1) month then

monthly for (2) additional

The Maintenance Director

to ensure compliance

was in-serviced on the requirements noted on

the 2567 on 5/28/18.

with K920.

months June - August 2018

If continuation sheet Page 5 of 6

		E & MEDICAID SERVICES		0	FORM APPRON MB NO. 0938-0:
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPL A BUILDING	(X3) DATE SURVEY COMPLETED		
		445516	B WING		05/14/2018
1	PROVIDER OR SUPPLIER	EHABILITATION CENTER	30	REET ADDRESS, CITY, STATE, ZIP CODE 6 W DUE WEST AVE ADISON, TN 37115	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
The state of the s	AM - 10:48 AM, revolutions in the following at Room 3 (multiple b. Room 217 NFPA 99, 10.2.3.6 (2). The maintenance as these deficiencies w	2 (2012 Edition)  05/14/2018 between 10:24 ealed unapproved power g patient rooms: power strips)  2012 Edition)  ssistant was present when ere identified, and were later administrator during the exit	K 920	4. The results of the weekly & monthly audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of K920. June – August 2018.  The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Service Director, Dietary Manager, Housekeep & Laundry Director, and Maintenance Director.	
1					